Form Instructions

For HHAs' Completion of the Home Health Advance Beneficiary Notice (HCFA-R-296).

Upon final OMB approval of this Home Health Advance Beneficiary Notice (HHABN), complete instructions will be formally published in the Home Health Agency Manual and the Medicare Intermediary Manual. These instructions will be the official Medicare program promulgation of policy and procedures that Home Health Agencies and Regional Home Health Intermediary (RHHIs) are to follow with respect to the HHABN.

i. Page 1 - Heading of HHABN--

a. "Home Health Agency Letterhead"--Put your (HHA's) name, address and phone number at the top of both pages of the notice; include your logo (if any) on the first page.

b. Date of Notice"--Enter the date you delivered the HHABN, i.e., gave it personally to the beneficiary or to the person acting on the beneficiary's behalf. Where personal delivery is not possible, enter both the date you notified the beneficiary by telephone and the date you mailed the notice.

c. "Beneficiary name" Line--Enter the name of the beneficiary; do not substitute the name of an authorized representative.

d. "Medicare # (HICN) Line--Enter the beneficiary's health insurance claim number.

e. "Attending physician" Line--Enter the attending physician's name.

f. "Physician's telephone number" Line--Enter the attending physician's telephone number.

ii. Page 1 - Body of HHABN--

a. Check the appropriate box for the reason why Medicare will not pay.

b. In the paragraph entitled "Why Won't Medicare Pay for My Services", in the first blank ("we, ___, have looked …"), enter your agency's name. In the second blank ("We expect Medicare will not pay for _____"), specify the home health care services for which you expect that Medicare will not pay, in sufficient detail so that the beneficiary can understand precisely what services may not be furnished. In the third blank ("after ___"), enter the date on which services are scheduled to end or be reduced. In the fourth blank ("because _____"), give the specific reason why you expect Medicare to deny payment. The reason(s) cited must be sufficiently specific to allow the beneficiary to understand the basis for your expectation that Medicare will deny payment, and, if necessary, to gather evidence to the contrary from a physician and/or others in support of the coverage of such services.

c. In the paragraph entitled "What Does this Mean for Me?", in the blank "Estimated Cost: $____", the beneficiary may jot down the estimated cost of the services after having asked you for that estimate. You may choose to provide the beneficiary with an estimated cost of the services by filling in that blank yourself, but that is entirely optional and not required.

d. "If you do not hear from Medicare …" Line-- Enter the name and telephone number of the servicing Regional Home Health Intermediary.

e. "Please call us at:____" Line-- Enter your agency's telephone number.

iii. Page 2 - HHABN Signature Page--

a. "Beneficiary name" blank - enter the name of the beneficiary; do not substitute the name of an authorized representative.

b. "Medicare # (HICN) blank - enter the beneficiary's health insurance claim number.

c. "What Do I Do Right Now?" section: In the ". . . these home health services: _____" blank, enter the specific home health services not expected to be covered (use the same description as in section ii.b., second blank, above).

d. Options A, B, & C - Check Boxes-- The beneficiary must select an option by checking one of the three boxes.

e. In the signature section of the page, in the "On: ___" blank, the beneficiary enters the date that he or she, or the person acting on his or her behalf, received the ABN. In the "Date of signature" blank, the beneficiary, or person acting on his or her behalf, enters the date on which he or she signed the HHABN. In the "Signature of beneficiary . . .", blank, the beneficiary, or person acting on his or her behalf, must sign his or her name.

iv. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displayss a valid OMB control number. The valid OMB control number for this information collection is 0938-0781. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, MD 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington D.C. 20503.